Psychosocial interventions for caregivers of people with dementia: a systematic review
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Authors' objectives
To identify the type of components that have been utilised in psychosocial or psychoeducational interventions for dementia caregivers, and to evaluate the success of the different components or combination of components in producing positive outcomes for dementia caregivers.

Searching
PsycLIT (from 1970 to 06/2000), MEDLINE (from 1966 to 10/2000), the ISI Science Citation Index and Social Sciences Citation Index (from 1980 to 09/2000) and the Cochrane Library (Issue 3, 2000) were searched. The search terms were listed in the paper. In addition, the reference lists of relevant studies were checked for additional studies meeting inclusion criteria. Non-English language studies were excluded from the review.

Study selection
Study designs of evaluations included in the review
The authors did not specify any inclusion criteria relating to study design. Case studies were excluded.

Specific interventions included in the review
Studies using psychosocial interventions that focused directly on improving the psychological well-being and/or social well-being of caregivers of individuals with dementia were eligible for inclusion. Psychosocial interventions were defined as techniques designed to utilise cognitive, behavioural or social mechanisms of action. These interventions were seen as distinct from medical and/or pharmacological techniques. Studies involving interventions directed primarily at the care-recipient or exclusively at improving caregivers' practical caring skills were excluded, as were studies assessing the effect of respite care on the caregiver unless they also intervened directly with the caregiver.

Participants included in the review
Studies involving caregivers of individuals with dementia were eligible for inclusion. Studies that did not stipulate the care-recipients illness, or included care-recipients with illness other than dementia, were excluded.

Outcomes assessed in the review
Studies focusing on directly improving psychological well-being and/or social well-being were eligible for inclusion. Studies that did not provide an analysis of the outcome using standardised measures were excluded, as were studies that relied exclusively upon the caregivers' reports of their levels of satisfaction with the intervention(s) as an outcome measure. The outcomes selected by the included studies were classified according to five categories: levels of knowledge, psychosocial well-being, caregiver burden, social outcomes and general. Psychosocial well-being covered measures of depression, mental health, anxiety and self-esteem. Caregiver burden covered measures of distress with problem behaviours displayed by the care-recipient. Social outcomes covered measures of the amount of support received, satisfaction with support, perceived support and the relationship between the caregiver and the care-recipient. The general category covered measures of life satisfaction, quality of life, locus of control and coping.

How were decisions on the relevance of primary studies made?
The authors do not state how the papers were selected for the review, or how many of the reviewers performed the selection.

Assessment of study quality
Quality was not systematically assessed, although aspects of it were discussed in the text.

Data extraction

The authors do not state how the data were extracted for the review, or how many of the reviewers performed the data extraction. The categories of data extracted included sample characteristics, attrition rate, group allocation, components and duration of the intervention, and findings.

Methods of synthesis
How were the studies combined?
The studies were combined using a descriptive approach. The studies were grouped in terms of category of outcome, and then according to both the general efficacy of the intervention and the efficacy of intervention components.

How were differences between studies investigated?
Study details were examined by the authors and any differences between the studies relating to aspects such as intervention, outcome measures and study designs, were noted.

Results of the review
Forty studies with a total of 7,353 participants were included: 21 with a control group or a wait-list control group (n=6,564); 16 without a control group, or with a control group but did not conduct between-group analysis (n=668); and 3 comparing different interventions without a control group (n=121).

Psychological well-being (29 studies): 18 (41%) of the 44 interventions evaluated, reported improvements in psychological well-being.

Caregiver burden (22 studies): 9 (30%) of the 30 interventions evaluated, reported improvements in caregiver burden.

Social outcomes (13 studies): 5 (22%) of the 13 interventions evaluated, reported improvements in social outcomes.

The studies did not generally produce consistent improvements in the well-being of caregivers, with approximately two thirds of the interventions targeted at dementia caregivers not producing the desired outcome. Participants in the interventions rarely exhibited any deterioration in the outcomes measured. Among those studies that did show improvements, the inclusion of social components (e.g. social support) or a combination of social and cognitive (e.g. problem-solving) components seemed to be relatively effective.

Authors' conclusions
There is little evidence that the interventions consistently produce positive benefits for dementia caregivers in terms of improved psychological well-being, burden or social outcomes. The studies reviewed show that it is possible to produce consistent improvements in the caregivers' knowledge of the care-recipients illness, but knowledge appears to be unrelated to psychological and social outcomes. The inclusion of social components in interventions, or a combination of social and cognitive components, appears to be relatively effective in improving psychological well-being. The review was hindered by a number of methodological problems (e.g. poor description of the intervention) and the included studies had small sample sizes. Any conclusions must, therefore, be treated with caution.

CRD commentary
The aims of the review were clearly stated and were well supported by a priori defined inclusion and exclusion criteria. Relevant sources were searched to identify articles, but only English language studies were eligible for inclusion and searches for unpublished studies were not reported. Hence, it is possible that relevant studies were omitted from the review. The methodological quality of the included studies, although not systematically assessed, was discussed in some detail in the review. Relevant details of the included studies were clearly presented and the authors discussed a number of aspects on which the studies differed. The studies were suitably synthesised using a descriptive format and this approach was appropriately justified by the authors. Details relating to the review process (i.e. how decisions on the relevance of primary studies were made and how the data were extracted) were not reported and, therefore, it is not possible to determine how rigorous this process was. The authors' conclusions follow on from the findings of the review and they are correct to warrant caution when interpreting the results.
Implications of the review for practice and research

Practice: The authors state that the inclusion of social components in interventions, or a combination of social and cognitive components, appears to be relatively effective in improving psychological well-being.

Research: The authors state that a systematic approach to the investigation of interventions with caregivers is required, where the components are carefully contrasted in appropriately designed studies of sufficient size.

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This is a critical abstract of a systematic review that meets the criteria for inclusion on DARE. Each critical abstract contains a brief summary of the review methods, results and conclusions followed by a detailed critical assessment on the reliability of the review and the conclusions drawn.